		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026286

Facility Name: Holy Family Health Center

Address: 2380 East Dempster (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

Telephone Number: (847)296-3335 **Fax #** (847)296-2027

IDPA ID Number: 363121158001

Date of Initial License for Current Owners: 5/1/1981

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael Lawrence **Telephone Number:** (312)980-2973

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2002 to 6/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) Michael Lawrence, CPA, Senior Manager
(Firm Name & Address) Blackman Kallick Bartelstein, LLP, 10 S. Riverside Plaza Chicago, IL 60606
(Telephone) (312)207-1040 Fax # (312)756-3973

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5/1/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	260	Intermediate (ICF)	235	93,375	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	362	TOTALS	337	130,605	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,778	7,644	8,364	22,786	8
9	SNF/PED					9
10	ICF	21,036	17,485		38,521	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,814	25,129	8,364	61,307	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.94%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 8,364

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2003 Fiscal Year: 6/30/2003

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	668	848	491	2,007		2,007		2,007			1
2	Food Purchase		963,671		963,671		963,671	(18,384)	945,287			2
3	Housekeeping	301,392	38,964	8,258	348,614		348,614		348,614			3
4	Laundry	155,307	52,053	4,365	211,725		211,725		211,725			4
5	Heat and Other Utilities			257,678	257,678		257,678	(2,162)	255,516			5
6	Maintenance	132,657	24,026	79,582	236,265		236,265	(779)	235,486			6
7	Other (specify):* Security Services	23,653	24		23,677		23,677		23,677			7
8	**TOTAL General Services**	613,677	1,079,586	350,374	2,043,637		2,043,637	(21,325)	2,022,312			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	3,479,347	114,315	9,179	3,602,841		3,602,841	(10,247)	3,592,594			10
10a	Therapy	405,028	13,024	62,230	480,282		480,282		480,282			10a
11	Activities	208,473	4,065	3,371	215,909		215,909	(267)	215,642			11
12	Social Services	54,800	145	489	55,434		55,434		55,434			12
13	Nurse Aide Training											13
14	Program Transportation			48	48		48		48			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,147,648	131,549	93,317	4,372,514		4,372,514	(10,514)	4,362,000			16
	C. General Administration											
17	Administrative	193,604	614	871,025	1,065,243		1,065,243	(635,271)	429,972			17
18	Directors Fees											18
19	Professional Services			2,992	2,992		2,992	246,923	249,915			19
20	Dues, Fees, Subscriptions & Promotions			3,947	3,947		3,947		3,947			20
21	Clerical & General Office Expenses	146,025	10,119	28,311	184,455		184,455	(761)	183,694			21
22	Employee Benefits & Payroll Taxes			1,439,318	1,439,318		1,439,318		1,439,318			22
23	Inservice Training & Education			4,032	4,032		4,032		4,032			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			110	110		110		110			25
26	Insurance-Prop.Liab.Malpractice			140,983	140,983		140,983		140,983			26
27	Other (specify):*											27
28	**TOTAL General Administration**	339,629	10,733	2,490,718	2,841,080		2,841,080	(389,109)	2,451,971			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,100,954	1,221,868	2,934,409	9,257,231		9,257,231	(420,948)	8,836,283			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

HOLY FAMILY HEALTH CTR
FYE 6/30/03
SCHEDULE OF OTHER GENERAL SERVICE
PAGE 3A

84224	10	SECU-PRODUCTIVE SA	21,915.35
84224	20	SECU-NON-PRODUCTIV	1,905.94
84224	25	SECU-SALARY BENEFI	(168.46)
84224	410	SECU-OFFICE SUPPLI	24.38

TOTAL TO LINE 7 SCH V 23,677.21

Facility Name & ID Number Holy Family Health Center #0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			386,937	386,937		386,937		386,937			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			250,930	250,930		250,930	(94,427)	156,503			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,036	39,036		39,036		39,036			35
36	Other (specify):*											36
37	**TOTAL Ownership**			676,903	676,903		676,903	(94,427)	582,476			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		600,394		600,394		600,394		600,394			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		76		76		76		76			41
42	Provider Participation Fee			183,871	183,871		183,871		183,871			42
43	Other (specify):* **Lab & Radiology**		13,994		13,994		13,994		13,994			43
44	**TOTAL Special Cost Centers**		614,464	183,871	798,335		798,335		798,335			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,100,954	1,836,332	3,795,183	10,732,469		10,732,469	(515,375)	10,217,094			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,384)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(94,427)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see attached	(14,333)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (127,144)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(388,231)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (388,231)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (515,375)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Holy Family Health Center

ID# 0026286

Report Period Beginning: 7/1/2002

Ending: 6/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing expense	$ (117)	17	1
2	Marketing expense	(742)	21	2
3	Covenant expenses for housing	(491)	6	3
4	Covenant expenses for housing	(2,162)	5	4
5	Covenant expenses for housing	(19)	21	5
6				6
7	Employee meals-not benefit related	(288)	6	7
8	Employee meals-not benefit related	(10,247)	10	8
9	Employee meals-not benefit related	(267)	11	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,333)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Holy Family Health Center **#** 0026286 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18,384)	0	0	0	0	0	0	0	0	0	0	(18,384)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,162)	0	0	0	0	0	0	0	0	0	0	(2,162)	5
6	Maintenance	(779)	0	0	0	0	0	0	0	0	0	0	(779)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(21,325)	0	0	0	0	0	0	0	0	0	0	(21,325)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(10,247)	0	0	0	0	0	0	0	0	0	0	(10,247)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(267)	0	0	0	0	0	0	0	0	0	0	(267)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(10,514)	0	0	0	0	0	0	0	0	0	0	(10,514)	16
	C. General Administration													
17	Administrative	(117)	(635,154)	0	0	0	0	0	0	0	0	0	(635,271)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	246,923	0	0	0	0	0	0	0	0	0	246,923	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(761)	0	0	0	0	0	0	0	0	0	0	(761)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(878)	(388,231)	0	0	0	0	0	0	0	0	0	(389,109)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,717)	(388,231)	0	0	0	0	0	0	0	0	0	(420,948)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Holy Family Health Center** **#** **0026286** **Report Period Beginning:** **7/1/2002** **Ending:** **6/30/2003**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(94,427)	0	0	0	0	0	0	0	0	0	0	(94,427)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(94,427)	0	0	0	0	0	0	0	0	0	0	(94,427)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(127,144)	(388,231)	0	0	0	0	0	0	0	0	0	(515,375)	45

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See attached list				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Risk mgt, emplyee health, IS, mat	$	Resurrection Health Care	100.00%	$ 246,923	$ 246,923	1
2	V	17	Finance, accounting, administration support		Resurrection Health Care	100.00%	235,754	235,754	2
3	V	17	Intercompany accrual	870,908	Resurrection Health Care	100.00%		(870,908)	3
4	V	39	Intercompany pharmacy	522,401			522,401		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,393,309			$ 1,005,078	$ * (388,231)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	none								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection HC/Medical Ctr
Street Address: 7435 W. Talcott Ave
City / State / Zip Code: Chicago/IL/60631
Phone Number: ((773)774-8000
Fax Number: ((773)594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Risk mgt, emplyee health, IS, materials mgt				$	$		$ 246,923	1
2	17	Finance, accounting, administration support							235,754	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 482,677	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	National City		x	Mortgage	$38,313.00	11/10/94	$ 5,623,000	$ 3,674,866	11/04	6.5300	$ 250,930	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$38,313.00		$ 5,623,000	$ 3,674,866			$ 250,930	9
	B. Non-Facility Related*											
10	Interest Income Offset										(94,427)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (94,427)	14
15	TOTALS (line 9+line14)						$ 5,623,000	$ 3,674,866			$ 156,503	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

NOT APPLICABLE

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holy Family Health Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026286

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		NOT APPLICABLE	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 136,250 B. General Construction Type: Exterior Face Brick Frame Steel Number of Stories 6

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use		1981	$ 610,897	1
2	Business Use		1984-2000	312,530	2
3	TOTALS			$ 923,427	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	362		1981	1963	$ 5,610,288	$ 153,162	26	$ 153,162	$	$ 5,258,758	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1981	39,944	288	various	288		39,148	9
10	Land Improvements			1982	3,300		15			3,300	10
11	Land Improvements			1983	16,546		15			16,546	11
12	Land Improvements			1985	2,758		15			2,758	12
13	Land Improvements			1987	26,060		10			26,060	13
14	Land Improvements			1991	2,934		8			2,934	14
15	Land Improvements; Repaving dempster lot			1996	6,944	694	10	694		4,859	15
16	Land Improvements: Utility pole			1996	1,908	127	15	127		890	16
17	Building Improvements			1981	30,116	1,503	various	1,503		24,633	17
18	Building Improvements			1982	38,889	211	20	211		38,889	18
19	Building Improvements			1983	137,540	686	various	686		104,816	19
20	Building Improvements			1984	161,928	8,084	various	8,084		123,311	20
21	Building Improvements			1985	140,002		various			140,002	21
22	Building Improvements			1986	74,495	1,510	15	1,510		66,152	22
23	Building Improvements			1987	81,758	1,273	various	1,273		81,758	23
24	Building Improvements			1988	9,477	622	various	622		9,336	24
25	Building Improvements			1989	29,180	1,962	various	1,962		27,476	25
26	Building Improvements			1990	119,639	10,442	various	10,442		113,084	26
27	Building Improvements			1991	209,393	12,221	various	12,221		170,806	27
28	Building Improvements			1992	47,000	1,625	10	1,625		47,000	28
29	Building Improvements			1992	79,513	6,097	various	6,097		67,071	29
30	Building Improvements			1993	55,142	3,941	various	3,941		39,411	30
31	Building Improvements			1993	7,044	470	15	470		4,698	31
32	Building Improvements			1994	86,489	7,515	various	7,515		67,634	32
33	Buidling Improvements #20-4			1995	5,035	458	11	458		3,663	33
34	Buidling Improvements #20-5			1995	5,469		5			5,469	34
35	Buidling Improvements #20-5			1995	7,988	726	11	726		7,141	35
36	Buidling Improvements #20-5			1995	3,648	365	10	365		2,919	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Buidling Improvements #21-4	1995	$ 94,827	$ 8,621	11	$ 8,621	$	$ 68,967	37
38	Buidling Improvements #21-5	1995	34,922	3,175	11	3,175		25,399	38
39	Buidling Improvements #21-5	1995	1,423	142	10	142		1,137	39
40	Buidling Improvements #26-4	1995	6,906	460	15	460		3,681	40
41	Buidling Improvements #26-5	1995	6,358	424	15	424		3,392	41
42	Buidling Improvements: Carpeting for facility	1996	43,550		5			43,550	42
43	Buidling Improvements: Rudd water heater tank	1996	825	83	10	83		580	43
44	Buidling Improvements: Rekey/Lock/Latches	1996	13,413	894	15	894		6,258	44
45	Buidling Improvements: Upgrade East elevator	1996	35,024	1,751	20	1,751		12,258	45
46	Buidling Improvements: Wall covering in dining room	1996	7,240		5			7,240	46
47	Buidling Improvements: Phone system and call system	1996	44,556	4,456	10	4,456		31,192	47
48	Buidling Improvements: Remodeling 3rd floor patient rooms	1996	316,547	21,103	15	21,103		147,722	48
49	Buidling Improvements: Tiling of shower room	1996	1,355	68	20	68		476	49
50	Buidling Improvements: Cabinets and shower doors	1996	15,698	785	20	785		5,495	50
51	Double face exterior sign	1997	5,174	517	10	517		3,103	51
52	Refurbish 2404 sign (Business office)	1997	2,428	243	10	243		1,457	52
53	Sealcoating parking lot area	1997	3,804	380	10	380		2,280	53
54	Painting, Wallcovering, tile replacement of nursing station	1997	102,440	6,829	15	6,829		40,975	54
55	Heaters convector	1997	3,240	324	10	324		1,944	55
56	Emergency phones in elevators-West	1997	1,264	126	10	126		756	56
57	Air Dampers - East Building	1997	2,099	210	10	210		1,260	57
58	Boilers for East Building	1997	4,310	287	15	287		1,723	58
59	Carpeting Room 215	1997	650	14	5	14		650	59
60	Air Handler of West Building	1997	1,450	145	10	145		833	60
61	Painting, wallcovering, floor replacement of 2 West station	1998	34,662	2,311	15	2,311		11,555	61
62	Painting, wallcovering, floor replacement of 4 West station	1998	77,327	5,155	15	5,155		25,776	62
63	Painting, wallcovering, floor replacement of 5 West station	1998	76,450	5,097	15	5,097		25,485	63
64	30 Ton Chiller	1998	17,670	1,178	15	1,178		6,510	64
65	Fire Dampers in bath rooms	1998	7,135	476	15	476		2,380	65
66	Repair water main from Department 300	1998	3,887	389	10	389		1,944	66
67	Gutter replacement of east building	1999	6,400	640	10	640		2,560	67
68	Painting, wallcovering, floor replacement of 2 East station	1999	62,793	4,186	15	4,186		16,744	68
69	Replacement of Tran Compressor	1999	7,063	471	15	471		1,881	69
70	TOTAL (lines 4 thru 69)		$ 8,083,317	$ 284,921		$ 284,921	$	$ 7,007,683	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,083,317	$ 284,921		$ 284,921	$	$ 7,007,683	1
2	Call system upgrade 1 West	1999	33,238	3,324	10	3,324		13,296	2
3	Call system upgrade 3 West	1999	17,274	1,727	10	1,727		6,911	3
4	Painting, wallcovering, floor replacement of 4 West station	1999	2,082	139	15	139		553	4
5	Painting, wallcovering, floor replacement of Physical Therapy	1999	8,665	578	15	578		2,312	5
6	Construction of Parking Lot	2000	227,278	11,364	20	11,364		34,092	6
7	Landscaping	2000	7,208	721	10	721		2,162	7
8	Replace east elevator hydrolift	2000	33,472	2,231	15	2,231		6,695	8
9	Repair decking	2000	7,000	467	15	467		1,400	9
10	Door replacement	2000	3,035	304	10	304		912	10
11	Construction of Parking Lot	2001	15,451	813	19	813		1,627	11
12	2380 Building remodeling	2001	6,985	699	10	699		1,049	12
13	Freight elevator gate	2001	1,300	87	15	87		173	13
14	Door replacement	2001	3,378	282	12	282		564	14
15	Gas Steamer - connection with Booster	2001	7,507	500	15	500		1,000	15
16	Water Main Repair	2002	8,109	405	20	405		506	16
17	Building, Reception and office improvements	2002	199,513	13,301	15	13,301		16,626	17
18	Installation of new WEIL Pump	2002	3,438	688	5	688		860	18
19	Repair Flat Roof To Wood Deck	2002	9,445	945	10	945		1,181	19
20	Telephone cables	2002	16,900	1,690	10	1,690		2,113	20
21	Topographic Mapping of entire facility	2002	8,316	554	15	554		693	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,702,911	$ 325,738		$ 325,738	$	$ 7,102,407	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,702,911	$ 325,738		$ 325,738	$	$ 7,102,407	1
2	7 New Signs	2002	7,744	387	10	387		387	2
3	1 New SIGN	2003	5,487	274	10	274		274	3
4	NORSTAR DIGITAL TRUNK CARTRTIDGE, DTI/ PRI ASSY.	2003	5,425	543	5	543		543	4
5	PROGRAMMING - DIRECT TV	2003	15,000	1,500	5	1,500		1,500	5
6	ELECTRICAL EQUIPMENT AND LABOR	2002	24,029	801	15	801		801	6
7	EXTERIOR & INTERIOR RENOV.-FR. 03/30/02 TO 04/26/02	2002	10,381	346	15	346		346	7
8	INSTALL BUMPER/CRASH	2002	15,049	752	10	752		752	8
9	NEW CIRCUIT IN BSMT	2002	6,155	205	15	205		205	9
10	KRONOS CLOCK- REPLACE JACK, INSTALL JACK CORD	2002	265	9	15	9		9	10
11	NEW DOOR LOCKS	2002	8,575	286	15	286		286	11
12	OVERHEAD PAGING SYSTEM	2002	2,500	125	10	125		125	12
13	ACCOUNTING DEPT.RELOCATING TO DES PLAINES	2002	1,613	54	15	54		54	13
14	DISCONNECT FURN. RE-WIRE- AT HOLY FAMILY-DES PL.	2002	2,995	150	10	150		150	14
15	WROUGHT IRON PIPE RAIL	2003	1,820	46	20	46		46	15
16	INSTALL RACEWAYS FOR VOICE DATA LINES	2003	770	39	10	39		39	16
17	BASEMENT OFFICE BUILDING RENOVATION	2003	2,755	92	15	92		92	17
18	CONSTRUCTION	2002	127,916	1,640	39	1,640		1,640	18
19	EXTERIOR PAINTING OF TOWER ON TOP	2003	14,810	494	15	494		494	19
20	SIGN	2003	10,000	500	10	500		500	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,966,199	$ 333,980		$ 333,980	$	$ 7,110,648	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,467,119	$ 40,882	$ 40,882	$		$ 1,104,039	71
72	Current Year Purchases	44,144	2,144	2,144		10	2,144	72
73	Fully Depreciated Assets	830,058					830,058	73
74								74
75	TOTALS	$ 2,341,321	$ 43,026	$ 43,026	$		$ 1,936,241	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	1987 Ford Van	1992	$ 5,000	$	$	$	5	$ 5,000	76
77	Maintenance	1992 Ford F250	1992	18,860				5	18,860	77
78	Facility	1998 Saturn Wagon	1997	10,891				5	10,891	78
79	See attached schedule PG 13A			68,838	9,931	9,931			66,962	79
80	TOTALS			$ 103,589	$ 9,931	$ 9,931	$		$ 101,713	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,334,536	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 386,937	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 386,937	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,148,602	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Holy Family
Provider # 0026286
Schedule 13A
Vehicle Depreciation

Description	Model	Year	Cost	BOY AD	7/1/2002 Book Value	Current Depreciation	S/L Depreciation	Life	Accumulated Depreciation	Line Ref
Resident T	1998 Dodge Caravan SS with wheel chair	1998	38,811	36,386	2,426	2,426	2,426	4	38,811	79
Facility	1998 Dodge 10 Passenger Van	1999	30,027	20,644	9,383	7,507	7,507	4	28,151	79
	Total		68,838			9,931	9,931		66,962	

TO LINE 37, SCH XI

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 39,036 Description: SEE ATTACHED SCHEDULE PG 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Holy Family
Provider # 0026286
Schedule 14A

Rental Equipments For HFNRC's FY2003 Cost Reports

Dept	Subaccount	Vender	Equipment Description	
67524	710	Professional medical,	Kendall Foot Pump	4,088
68024	710	Professional medical,	Kendall Foot Pump	11,995
83424	710	Praxair Distribution In	Cylinder (med high pressure<,	3,467
83424	710	AGA Linde healthcare	451-750G Med Lox	
85024	710	Kreg Therapeutics, In	Microair Therapeutic Unit	35
93924	710	Pitney Bowes Credit C	Mailing System - Model No. FD	3,141
94124	710	IOS Capital	Ricoh AF700, AF551	5,944
94724	710	Ikon Office Solution	Sha SF-2025 Copier	10,366
94724	710	IOS Capital	Ricoh AF700, AF551	
			TOTAL RENTAL	39,036
			LINE 16, SCH XII	

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-1	hrs	$ 57,205		$ 32,110	$		$ 89,315	1
2	Licensed Speech and Language Development Therapist	10A-1	hrs	182		16,114			16,296	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1	hrs	156,195		47,626			203,821	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				600,394		600,394	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 213,582		$ 95,850	$ 600,394		$ 909,826	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 995,826	$	1
2	Cash-Patient Deposits	76,106		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,074,825))	1,381,775		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,128,725		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	94,251		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,676,683	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	923,427		13
14	Buildings, at Historical Cost	5,740,669		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,670,440		16
17	Accumulated Depreciation (book methods)	(9,148,602)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,185,934	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,862,617	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 121,306	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,968		28
29	Short-Term Notes Payable	202,100		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 356,374	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,472,766		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Related party notes	7,542,796		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 11,015,562	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,371,936	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,509,319)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,862,617	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,863,245)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,863,245)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(646,074)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (646,074)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,509,319)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,858,630	1
2	Discounts and Allowances for all Levels	(3,549,538)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,309,092	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,490,659	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,490,659	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	83	13
14	Non-Patient Meals	18,384	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	805,602	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	32,877	20
21	Other Medical Services	73,191	21
22	Laundry	27,093	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 957,230	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	94,427	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 94,427	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc income	37,187	28
28a	Interrelated rental income	197,800	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 234,987	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,086,395	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,043,637	31
32	Health Care	4,372,514	32
33	General Administration	2,841,080	33
	B. Capital Expense		
34	Ownership	676,903	34
	C. Ancillary Expense		
35	Special Cost Centers	614,464	35
36	Provider Participation Fee	183,871	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,732,469	40
41	**Income before Income Taxes (line 30 minus line 40)****	(646,074)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (646,074)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,792	2,080	$ 62,391	$ 30.00	1
2	Assistant Director of Nursing	1,760	2,080	25,516	12.27	2
3	Registered Nurses	50,515	58,356	1,520,976	26.06	3
4	Licensed Practical Nurses	13,155	14,583	291,033	19.96	4
5	Nurse Aides & Orderlies	111,930	126,587	1,539,239	12.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,405	7,449	213,582	28.67	7
8	Rehab/Therapy Aides	10,217	11,432	191,445	16.75	8
9	Activity Director					9
10	Activity Assistants	3,525	3,822	48,633	12.72	10
11	Social Service Workers	3,883	4,315	54,799	12.70	11
12	Dietician	32	32	668	20.88	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,814	7,718	132,657	17.19	17
18	Housekeepers	28,196	31,207	301,392	9.66	18
19	Laundry	14,646	16,482	155,307	9.42	19
20	Administrator	2,080	2,080	107,120	51.50	20
21	Assistant Administrator					21
22	Other Administrative	3,368	3,584	86,458	24.12	22
23	Office Manager					23
24	Clerical	22,263	25,379	305,865	12.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,870	2,907	40,220	13.84	31
32	Other Health Care(specify)					32
33	Other(specify) SECURITY	1,957	2,149	23,653	11.01	33
34	TOTAL (lines 1 - 33)	285,408	322,242	$ 5,100,954 *	$ 15.83	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant		2,530	L10,C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		440	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,064	L11, C3	44
45	Social Service Consultant		489	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,523		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 1,490	L10, C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 1,490		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sister Elizabeth Tremb	Administrator	0	$ 107,120
Sister Machaline	Dir of Reimbrmt	0	47,616
Sandra Rudsinski	Dir of Admissn	0	38,868
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 193,604

B. Administrative - Other

Description	Amount
Resurrection Intercompany support	$ 870,908
Marketing	117
TOTAL (agree to Schedule V, line 17, col. 3)	$ 871,025
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Uniform D	Audit svc	$ 2,575
United PA	annual fee	16
Mediquist	Professional svc	44
Keane Care	AP microfilming	340
	legal fees	17
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,992

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,618
Unemployment Compensation Insurance	11,291
FICA Taxes	378,497
Employee Health Insurance	768,933
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement fund	191,471
Group Life, disability, vision	35,903
Employee assistance (SAP)	3,706
Tuiton reimbursement	6,212
Adoption program	67
Preemploy mentoring	6,620
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,439,318

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
n/a		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues and Subscriptions	3,947
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,947

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	0
Seminar Expense	0
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center **#** 0026286 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN-$4,615**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,437** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **183,871**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(18,384)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not completed yet- will forward**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **None apply**
Attach invoices and a summary of services for all architect and appraisal fees.